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Exploring Person-centredness in Emergency Departments: A literature review.

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ABSTRACT

Person-centred approaches to care delivery have been increasingly promoted in international policy and strategy, but despite this, there is evidence of failings within healthcare systems which negatively impact on the care experience for patients and staff. This paper explores the international literature on person-centredness within emergency departments (EDs). The Person-centred Practice Framework was used as the underpinning theoretical framework. This theory contends that staff must possess certain attributes to manage the care environment appropriately to deliver effective care processes in order to achieve effective person-centred outcomes for patients and staff. An initial search of the literature identified no relevant papers that discussed person-centredness as a concept within EDs. A further search using terms drawn from a definition of person-centredness revealed literature that reflected components of person-centredness. Themes that emerged included: medical-technical intervention; a culture of worthiness; managing the patient journey; nurse/doctor relationships; patients and relatives experience of care, and ED as a stressful environment. The themes can be mapped onto the Person-centred Practice Framework suggesting that components of person-centred practice have emerged from studies in a fragmented fashion, without consideration of person-centredness as a whole within an ED context.

Highlights

- Person-centredness as a concept has not been explored in the ED literature
- Emergency nurses focus more on medical tasks than patient wellbeing
- The ED culture affects the readiness of the context to deliver person-centred care
- Nurses' ability to manage ED is impacted on by processes outside their control
- The care experience for many ED staff and patients' is negative

INTRODUCTION

Person-centred approaches to care delivery have been increasingly promoted in international policy and strategy over the last decade as a means of enhancing standards of care (Laird et al 2015). Its translation into care delivery has been proven to have a positive impact on patients and staff (McCormack and McCance 2010). Improving the patient experience is concerned with more than just good clinical care. It includes being cared for with kindness, compassion and respect (Goodrich and Cornwell 2008). According to McCance et al (2013) this emphasises the need to focus on attitudes, behaviours and relationships that reflect the importance of working in ways that support a person-centred approach and puts the patient at the centre of care delivery.

BACKGROUND

Despite the apparent drive towards a person-centred approach recent inquiries in the United Kingdom (UK) have revealed substantial failings within the healthcare system which have had significant impact on the quality of patient care (Francis 2013, Berwick 2013). These reports highlighted inadequate communication, acceptance of poor standards and a culture that focused on systems rather than patients. Despite lessons which should have been learned from these inquiries care remains inadequate, and recent reports from emergency departments (EDs) highlight overcrowding, medical errors, prolonged delays in the treatment of pain and suffering, lengthy waiting times and patient and staff dissatisfaction (Canadian Association of Emergency Physicians 2015). Within the UK the ED experience continues to dominate the media with headlines portraying an environment that is the antithesis of person-centred care, for example, *“A&E units have become like warzones”* (The Telegraph 2013), *“Cancer patients 26 hours of hell on earth in A&E”* (Belfast Telegraph 2015) and *“Porter ‘fed up of seeing nurses crying’ over A&E problems”* (BBC News 2014).

Person-centredness as a concept

Person-centredness describes a standard of care that places persons at the centre of it by moving away from fragmented medically dominated care towards care that is relationship focused, holistic, and collaborative (McCance et al 2011). McCormack and McCance (2010) developed the Person-Centred Practice Framework which essentially comprises four domains: *prerequisites* which focus on the attributes of staff; *the care environment* which focuses on the context in which care is delivered; *person-centered processes* which focus on delivering care through a range of activities; and *expected outcomes* which are the results of effective person-centred nursing (McCormack and McCance 2010).

McCormack et al (2010) define person-centredness within nursing as

“An approach to practice established through the formation and fostering of therapeutic relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development” (p.13).

This paper aims to explore the international literature on person-centredness within Emergency Departments.

METHOD

The databases Proquest, Cumulative Index to Nursing and Allied Health (CINAHL), Medline Ovid and Embase were initially searched using keywords shown in table 1a. The inclusion period was January 2002 to February 2014. This revealed a dearth of relevant literature highlighting the lack of research in this area and therefore the need for a change in search strategy. A further search was conducted using keywords

shown in table 1b that are based on the core components of person-centredness and the above definition. The search was limited to articles published in English, relating to humans and adult age group.

Table 1: Search strategy

1a:Initial search strategy			
Keywords	Person centred Patient centred Client centred	AND	Accident and Emergency Emergency department Emergency room
1b: Further search strategy			
Keywords	Experience of care Values Beliefs Shared decision making Caring Culture Engagement Therapeutic relationships	AND	Accident and Emergency Emergency department Emergency room

The literature was reviewed by title, abstract, and then full-text by the lead author for inclusion. Studies were included if they were published in peer-reviewed journals, empirically based and focused on key person-centred aspects in ED. Reference lists were scanned for relevant literature (figure 1). A total of 39 articles were identified. These studies were assessed for quality using the Critical Appraisal Skills Programme (CASP 2014) and all were retained for inclusion. The findings are presented in table 2. The literature was varied in terms of country of origin giving a range of findings from different health care systems and cultures. The selected studies were evaluated using thematic analysis, by the lead author, to identify themes that were pertinent to person-centred practice, and the results were checked for final consensus by all authors.

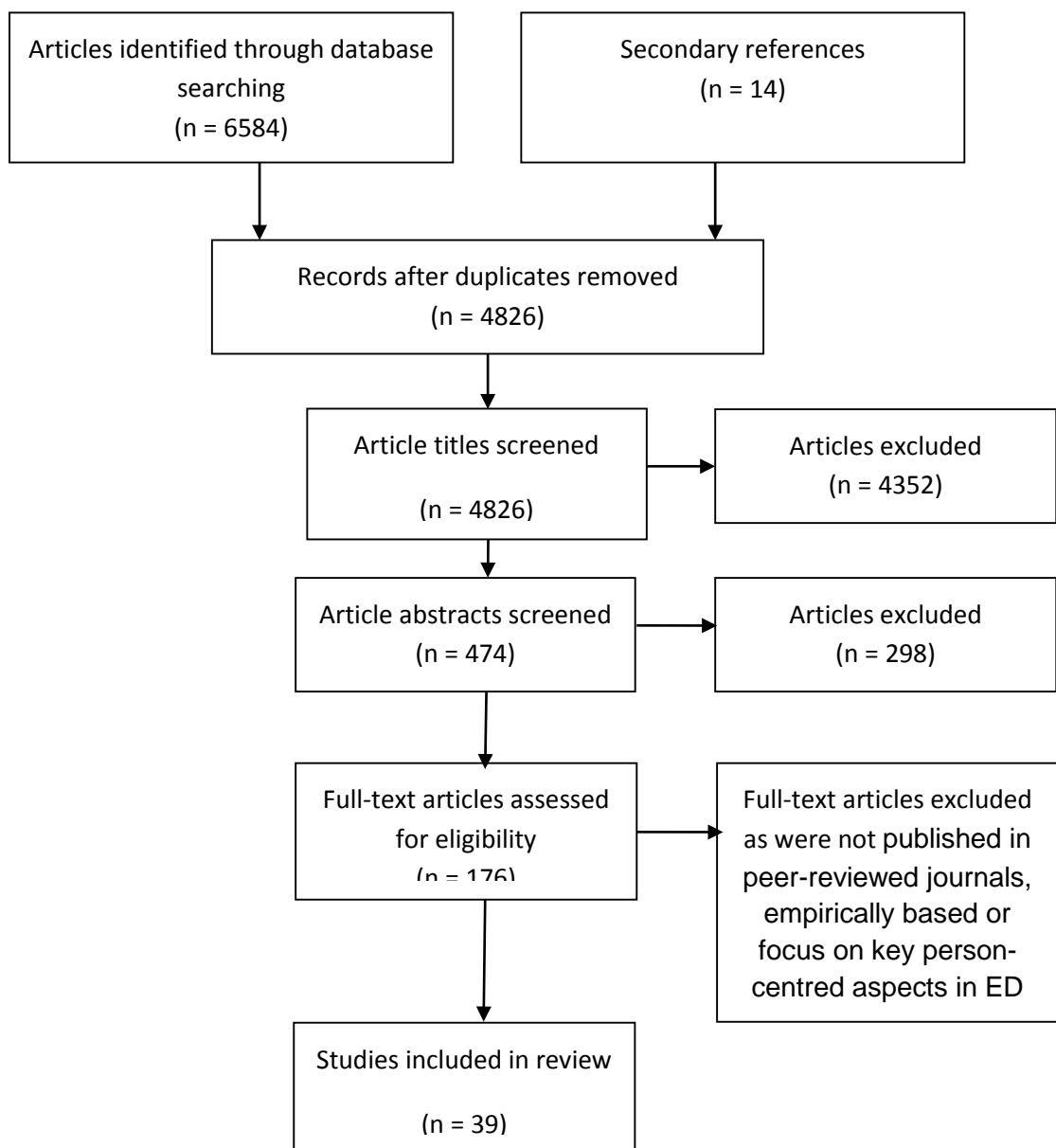


Figure 1. Prisma flow diagram of literature selection process

RESULTS

Analysis of the literature revealed six themes that could be described as characteristic of components of person-centredness within ED. These were medical-technical intervention; a culture of worthiness; managing the patient journey; nurse/doctor relationships; patients and relatives experience of care and a stressful environment.

Table 2: Literature relating to themes and key findings

Study and origin	Study design	Themes	Key findings
Nyström 2002 (Sweden)	Case study approach within a hermeneutic tradition.	Medical-technical intervention A culture of worthiness Nurse/doctor relationships	A lack of a holistic perspective was found. Nursing is not valued but medical, concrete tasks are. Nurses did not want supervision in nursing related aspects, they wanted it in medical and technical tasks. A caring attitude was interpreted as a personal characteristic. Non-urgent pts are too demanding during busy periods. Nurses are socialised by the social authority and status of medicine. Doctors are often irritated when nurses do not direct some patients to other forms of care
Sbailh 2002 (UK)	Observational study	A culture of worthiness Managing the patient journey through ED	ED nurses hurry colleagues and network with other settings to ensure each patient receives appropriate care but none take up more time than they need as this will mean time to see other pts is reduced. When numbers increase nurses are sensitive to minor injury work being less significant than majors.
Nyström et al 2003 (Sweden)	Case study approach within a hermeneutic tradition.	Medical-technical intervention Nurse/doctor relationships Patients and relatives experience of care	Care is fragmented. ED nursing was perceived as extension of medicine and the nurses appeared to not appreciate nursing. Medical goals are distinct, nursing's are not. Care is medically orientated and caring not seen as important. Patients' try to be 'good' pts. They are aware of ED demands and attempt to adapt their behaviour to fit with the ED environment.
Nyden et al 2003 (Sweden)	A life-world interpretative approach	Patients and relatives experience of care	Safety needs dominated. It was vital patients could trust the competence of the staff. When waiting times were long patients felt feelings of insecurity and unsafeness. Pts tried not to bother the nurses unnecessarily. Some tried to develop a better relationship with staff by joking with them. Pts appreciated nurses being kind and friendly.

Wright et al 2003 (USA)	Survey design	A culture of worthiness	There is a basic tension between ED work and needs of patients with serious mental health problems. ED environment is fast paced and chaotic and can exacerbate symptoms. Negative attitudes are quite prominent among ED staff.
Hislop and Melby (2003) (UK)	Phenomenology	A stressful environment	Staff saw themselves as being there in a caring capacity and could not understand why they should be the target of such verbal outbursts and physical abuse. Staff felt management did not understand what they faced daily. Some ED terminology has aggressive connotations.
Laposa et al 2003 (Canada)	Secondary analysis of previously reported data	A stressful environment	The interpersonal environment caused stress. Stress was created mostly by organizational factors with actual patient care being less stressful.
Kihlgren et al 2004 (Sweden)	Grounded theory	Medical-technical intervention Patients and relatives experience of care	There was a medical-technical culture and attention focused on the medical condition. Nursing care was characterised as meeting medical and technical demands. Patients were often more worried about their social condition than medical one. They greatly appreciated eye contact, and time taken to listen.
Winman and Wikblad 2004 (Sweden)	Non – participant observation	Medical-technical intervention	Aspects of uncaring were more common than caring. Nurses tended to engage with patient only when carrying out doctor's instructions. They concentrated on physical tasks and showed physically caring behaviours more often than affective caring behaviours.
Crilly et al 2004 (Australia)	Descriptive longitudinal cohort design study	A stressful environment	Precipitating factors associated with violence included waiting times, alcohol, drugs and behaviour associated with mental health illness.
Kihlgren et al 2005 (Sweden)	Observational study	Medical-technical intervention	Prioritising medical care, lack of time, workload, inexperienced doctors, working with death, poor referral documentation all prevent good care. There is an

		Managing the patient journey through ED	imbalance between inflow of patients and outflow in the ED.
Karro et al (2005) (Australia)	Exploratory design within a qualitative approach	Patients and relatives experience of care	Privacy breaches included overhearing others' conversations, seeing others' body parts or perceiving that they are overhead or seen. A minority of patients withhold information for fear of being overheard.
Coughlan and Corry 2007 (Ireland)	Qualitative approach	Managing the patient journey through ED Patients and relatives experience of care	The environment was compared to what would have expected to find in a low income country – overworked staff, overcrowding, trolleys and chairs lined up with patients awaiting admission, no privacy, unhygienic and lack of resources. Some patients were distressed by the treatment they received that they were in terror of returning to the ED.
Bridges 2008) (UK)	Narrative methodology (discovery interview technique)	Patients and relatives experience of care	Pts and their relatives described a feeling of not mattering, fear and anxiety, lack of continuity of care and discharge. They highly valued a person-centred approach from staff, with help and information tailored to their needs.
Kansagra et al 2008 (USA)	Survey design	A stressful environment	The consequences of workplace violence for the emotional well-being of staff include anger, anxiety, fear, and decreased job satisfaction.
Cluckey et al 2009 (USA)	Qualitative approach	Patients and relatives experience of care	Family members appreciated staff using a sound knowledge-base and interpersonal skills. Family members were sensitive to the nonverbal behaviours - tone of voice, pace and force of actions taken, and the ability to engage in active listening, nurses taking care of the patient, being present and fully engaged with them in the moment and small actions giving physical comfort.
Khokher et al 2009	Qualitative approach	Nurse/doctor relationships	Relationships with patients varied due to ability to control volume and pressure to see as many as possible meant

(Canada)		Patients and relatives experience of care	time brief and interaction not meaningful. Doctors are buffered from negative interactions due to their status. Nurses bore the main criticism from patients.
Smith et al 2009 (USA)	Grounded theory	A culture of worthiness	The ethos of palliative care conflicted with the ED culture. Patients waited for lengthy periods as were not a priority. Rooms were stark with stretchers. Drunk or aggressive pts were treated nearby. Doctors had inadequate training in pain management.
Dominguez-Gomez and Rutledge 2009 (USA)	Exploratory comparative design	A stressful environment	The most commonly reported symptoms of stress for Ed staff were intrusive thoughts about patients, avoidance of patients, difficulty sleeping or being easily annoyed.
Muntlin et al 2010 (Sweden)	Qualitative approach	Medical-technical intervention A culture of worthiness Managing the patient journey through ED	Staff objectified patients and spoke of them as conditions. They claimed non-urgent patients shouldn't be there and hindered their ability to do good work. The ED culture valued 'doing' and getting the patient through the system.
Möller et al 2010 (Sweden)	Phenomenography	Medical-technical intervention Patients and relatives experience of care	Patients had a fear of being forgotten in the waiting room and a feeling of not being welcome as there were too many pts there already. Staff concentrated on medical issues and forgot the patients' psychological needs.
Bailey et al 2011 (UK)	Qualitative study drawing on ethnographic methods.	A culture of worthiness	Palliative care has low status in ED. There is a feeling that death is 'out of place' yet it is common with trauma. ED teams are meticulously trained for resuscitation but not for patients at end-of-life.
Pich et al 2011 (Australia)	Qualitative approach	Nurse/doctor relationships A stressful environment	Nurses are most at risk of patient-related violence. Nurses were treated differently to doctors by patients. Nurses reported a sense of inevitability regarding patient-related violence and reported feeling degraded, frustrated and powerless, upset and disheartened. They recognised that

			the staff could contribute to patient violence and aggression.
Sanders et al 2011 (UK)	Narrative Case Study	Managing the patient journey through ED Nurse/doctor relationships	ED has a culture that is subject to externally-determined time targets that are enforced by a top-down system of surveillance and management. There is a power difference between doctors and nurses in ED. Nurses have responsibility for patient throughput and patients breaching targets, yet have very little power to control this.
Limbourn and Celenza 2011 (Australia)	Prospective cross-sectional study	Patients and relatives experience of care	Patients most valued being attended to promptly by a friendly doctor who was caring, concerned and attentive while appearing to work thoroughly, efficiently and competently, being listened to and receiving thorough explanation of their treatment, diagnosis and any advice given to them and having the opportunity to ask questions answered in simple language.
Marynowski-Traczyk and Broadbent 2011 (Australia)	Hermeneutic phenomenology	A culture of worthiness	The high-stimulus, highly technological ED environment is not conducive to mental health patients and ED nurses are poorly prepared for them. ED nurses find these "revolving door" patients frustrating.
Gilchrist et al 2011 (Australia)	Retrospective survey	A stressful environment	Participants felt that violence had increased over the duration of their time working in the ED. Reasons given were alcohol, drug use, waiting times mental illness, lack of understanding of the system.
Stathopoulou et al 2011 (Greece)	Descriptive correlational design	A stressful environment	ED nurses reported having sleep disturbances, anxiety and depressed mood due to their work.
Person et al 2012 (USA)	Ethnography	Medical-technical intervention A culture of worthiness	There is a culture unique to ED. The phrase, "the way we do things around here" demonstrates the ingrained values, beliefs, norms, and expectations of members within an organization or work unit. ED is high volume,

			fast paced, unpredictable. Staff find the work mostly rewarding.
Fry 2012 (Australia)	Ethnography	A culture of worthiness	Experienced triage nurses hold beliefs of how patients should behave that can impact on their practice. When these are breached there were negative consequences for patients who are not aware of these cultural expectations. The beliefs appear to result from notions of worthiness but are driven by notions of privacy, safety respect and equity.
Elmqvist et al 2011 (Sweden)	Phenomenology	Patients and relatives experience of care	Staff are interested in the physical aspect only and patients are rapidly examined for assessment of life-threatening conditions. There is a security in this but it engenders feelings of insecurity and abandonment.
Elmqvist et al 2012 (Sweden)	Phenomenology	Medical-technical intervention A culture of worthiness Managing the patient journey through ED Nurse/doctor relationships	ED staff employ adopted attitudes in an attempt to bring order to an unpredictable environment. The unpredictability of ED is exciting and challenging but also creates stress. Life-saving has the highest priority and staff are always in readiness for this. Work adopts a performance focus. Nursing staff are forced to be accessible to patients while waiting for the doctor to come. They need to continue caring for waiting patients as well as see new ones to maintain control of patient flow. Nurses find it stressful when the doctor does not come as they do not know what to tell the pts about waiting times.
Andersson et al 2012 (Sweden)	Qualitative exploratory study design	Managing the patient journey through ED	Nurses find it difficult to provide individualised care due to performing other tasks. Meeting basic patient needs becomes a task for unqualified staff.
Lau et al. 2012 (Australia)	Contemporary ethnography	A stressful environment	Busyness and long waiting times are important contributory factors to violence however human

			interaction factors have a more profound influence on it.
Bergman 2012 (USA)	Qualitative method informed by grounded theory	A culture of worthiness Managing the patient journey through ED Patients and relatives experience of care A stressful environment	Staff are over-whelmed due to patient volume, 'boarding' patients, the need for continuous prioritisation, lack of staff and inability to control patient flow. There is frustration at perceived abuse of ED and patients are referred to as "frequent fliers" and "regulars". A perceived lack of control is cited as a primary reason why colleagues quit or transfer out of the emergency dept.
Sawatzky and Enns 2012 (Canada)	Survey design	A stressful environment	Engagement was a key factor in nurse retention in ED and a significant predictor of intention to leave. Engagement was comprised of factors relating to nursing management, professional practice, collaboration with physicians, staffing resources and shift work.
Hillman 2013 (UK)	Ethnography	A culture of worthiness	Patients are categorised on the basis of medical and moral criteria and perceived moral worth. This process provides staff with a means to have control over what they determine to be inappropriate demands for the service. There are correct rules of patient behaviour and patients can be classed as 'legitimate' patients or not.
Nugus et al 2014 (Australia)	Ethnography	Managing the patient journey through ED	ED has an inflexible work capacity and space leading to overcrowding which reduces efficiency and increases the risk of medical error leading to adverse events. Staff had to manage their time across several patients to minimise the impact of waiting time leading to fragmented care.
Angland et al 2014 (Ireland)	Qualitative approach	A stressful environment	The main reasons for violence and aggression were waiting times, overcrowding, layout, lack of communication and staff attitudes towards patients, particularly at the end of a long shift or those who were deemed not appropriate to be there.

Medical-technical intervention

Kihlgren et al (2004), Muntlin et al (2010) and Winman and Wikblad (2004) all revealed a common finding of a medical-technical environment where value was placed on technology, medical status and patient throughput over caring. Two studies (Elmqvist et al 2012, Person et al 2012) highlighted how this was a cultural norm which ED staff employed to help them cope with working in an unpredictable, stressful environment. Nyström et al (2003) referred to this as conveyor belt style nursing. ED staff viewed the purpose of their role as one of saving lives, and felt that they were there to deal with emergencies and acutely ill patients which they found rewarding and exciting (Elmqvist et al 2012, Nyström 2002, Person et al 2012). Winman and Wikblad (2004) found that interactions with patients were mostly undertaken when carrying out medical tasks or undertaking doctor's instructions. The high value placed on performing medical tasks meant that nursing care had become an extension of medical care with nursing expertise not being perceived as important by ED nurses (Möller et al 2010, Nyström et al 2003). This was reinforced by a number of studies which found that when ED nurses spoke of expertise and competence they were referring to highly developed technical skills and medical tasks rather competence in caring (Nyström 2002, Nyström et al 2003, Winman and Wikblad 2004).

Nyström (2002) found that ED nurses had become totally involved in the paradigm of medicine and did not even recognise the nursing paradigm. An example of this attitude was found in a Swedish study involving twenty patients aged over 75 years (Kihlgren et al 2005, p605) where a nurse stated:

"It is difficult with nursing care. It is secondary for me as I am working in an ED..... We are not good at giving nursing care. We are trained in acute care, giving nursing care does not come automatically".

A culture of worthiness

The literature also identified a belief system where patients were valued for their legitimacy to be treated within the ED. Elmqvist et al (2012) identified that ED staff were always in readiness for lifesaving and described their work as running in a sprint race, performing quick measures for acutely ill patients. Some patient groups however presented a challenge for ED staff. Studies from Sweden, USA and UK all found that those with minor or routine complaints or conditions that could have been treated elsewhere were a frustration to staff and caused feelings of resentment (Muntlin et al 2010, Person et al 2012, Sbaih 2002) and took their attention away from the job of saving lives. Such patients were referred to in terms of “*regulars*” (Bergman 2012, p222) and having “*banal complaints*” (Nyström 2002, p415). Other studies identified that caring for those with end-of-life needs (Bailey et al 2011, Smith et al 2009) and mental health needs (Marynowski-Traczyk and Broadbent 2011, Wright et al 2003) was in conflict with the ED culture.

Two ethnographic studies undertaken by Fry (2012) in Australia and Hillman (2013) in the UK found that staff held collective beliefs about which patients were considered worthy of ED care. Fry referred to patients who were “*right*” and “*good*” (p124) while (Hillman 2013, p487) termed them as “*legitimate*” patients. Patients attending who breached these beliefs caused resentment which could result in negative consequences for them such as increased waiting times. For example nurses in Fry’s (2012, p123) study referred to a “*positive bag sign*”

“you have a positive bag sign, when I see the ambulance pull up and the bag’s on the trolley. I just immediately think, right, you’re in the waiting room”.

They believed that these patients came with the expectation of being ill enough to bypass the waiting room and go straight into the ED or a hospital bed. In contrast however, nurses felt if they were well enough to organise packing a bag they were

unlikely to be acutely unwell and could therefore take their place in the queue with the rest, unless staff deemed otherwise. While from an outsider's perspective this may appear to be based on staffs' value judgment of what they deemed to be worthy, researchers found that their attitudes were driven by notions of safety, respect and equity. This view is supported in an earlier study (Sbaih 2002) which found that similar attitudes derived from staffs' desire to ensure safe and effective care for those who really needed it rather than any moral judgement of worth.

Managing the patient journey through ED

The literature revealed that nursing staff had management responsibility within EDs, however, they appeared to have very little control over their environment. A number of studies revealed the emphasis was on getting the patient through the department as quickly as possible (Muntlin et al 2010, Nugus et al 2014, Sanders et al 2011) however processes both within and outside the ED impacted on their ability to do this. ED staff were at the mercy of other departments to allow them to transfer patients for admission or treatment (Bergman 2012, Kihlgren et al 2005, Muntlin et al 2010). Nurses in one Australian study described their department as *"completely constipated"*, *"gridlocked"* and *"bottlenecked"* (Nugus et al 2014, p5) which led to overcrowding, low staff satisfaction, decreased compliance with clinical guidelines, decision-making errors, an increase in the quantity of adverse events, and increased waiting times, causing patients to leave the department without being seen (Nugus et al 2014). The imbalance between inflow and outflow meant additional tests and treatment needed to be performed in the ED and nurses needed to continue caring for waiting patients as well as continuing to assess new patients (Elmqvist et al 2012, Kihlgren et al 2005). This further increased workload and responsibility and led to fragmented care (Andersson et al 2012, Nugus et al 2014, Sbaih 2002). In addition Coughlan and Corry (2007) found that the equipment, structure and design of EDs were constructed to facilitate transiting

patients and were not suitable for patients who had to wait for lengthy periods of time in that environment, all of which negatively impacted on the quality of care delivered. The fact that these studies were undertaken in Sweden, USA, UK, Australia and Ireland indicate that these are widespread issues within EDs.

Nurse-doctor relationships

A further paradox reported in the literature was that while nurses had managerial responsibility of the ED they did not have managerial control over medical staff working there. Two Swedish phenomenological studies highlighted how nurses deferred to doctors. Elmqvist et al (2012) found it was a source of stress to nurses when doctors did not come to see patients waiting in the ED. They were forced into trying to appease patients and give explanations for indeterminate waiting times over which they had no control. Nyström et al (2003) identified how nurses interceded with patients in an attempt to keep doctors happy indicating a deferential relationship and an awareness of their status in relation to medical staff. Nyström et al (2003) found that some doctors became irritated when nurses failed to direct inappropriate patients to other forms of medical care. One nurse, in order to avoid outbursts, reportedly questioned herself *“do I dare let this patient in to see this doctor?”* (p765).

Sanders et al (2011) presented a narrative case study on one nurse's experience of managing a busy ED in the UK which highlighted the power status differential between nurses and doctors. While she struggled to manage the system that was governed by externally enforced service targets, one doctor responded angrily to management's insistence of moving an ill patient on in the system in order not to breach a time target. The doctor's apparent disregard for a system which seemed to dominate and direct the nurse's role highlighted the different autonomy each felt in the workplace. There were further examples of this differing status in studies from Sweden, Canada and Australia

showing how patients and staff treated doctors and nurses differently. Doctors appeared to be buffered from negative interactions with patients due to their status, while nurses endured the main criticism and complaints (Khokher et al 2009, Nyström 2002). Pich et al (2011) interviewed six Australian triage nurses regarding their experiences of patient-related workplace violence. They found that patients treated nurses differently to doctors and indeed often stopped their abusive behaviour when a doctor came into their presence.

Patients and relatives experience of care

Several studies examined patient experience in ED and found what was important to them was how they experienced staff–patient interactions (Kihlgren et al 2004, Nydén et al 2003, Nystrom et al 2003), communication and information received (Bridges 2008, Limbourn and Celenza 2011), staff competence (Cluckey et al 2009, Nydén et al 2003) and having a family presence (Bridges 2008). Cluckey et al's (2009) study in USA found relatives were sensitive to nonverbal behaviours of nurses such as tone of voice, pace and force of actions being undertaken. They valued nurses taking care of the patient and engaging in active listening and being present and fully engaged with them in the moment.

Unfortunately the literature paints a generally negative picture in relation to how patients experienced care in EDs. One Swedish study (Nyström et al 2003) found dissatisfaction with care, a feeling of not being considered as an individual and a lack of caring as predominant features of patients' experience. Others described patients feeling abandoned, exposed, vulnerable, ashamed, ignored, insecure, frightened, forgotten or unwelcome (Elmqvist et al 2011, Möller et al 2010). Factors attributed to this included the quality of staff–patient interaction, (Coughlan and Corry 2007) fragmented care (Bergman 2012, Khokher et al 2009) and lack of privacy (Coughlan

and Corry 2007, Karro et al 2005). Coughlan and Corry (2007) found that the treatment received in one Irish ED caused some patients such distress that they were in terror of returning there. Some likened it to what would be expected in a low income country or following a major disaster.

There was some evidence however of patients' awareness and acceptance that the ED culture placed significance on physical rather than affective caring, and there was an impression that patients were prepared to tolerate this lack of psychological care in trade-off for having the physical aspect of their care treated. Two Swedish studies made reference to patients feeling a reassurance that they were in the ED and had a sense of security in that they would be treated there (Elmqvist et al 2012, Nydén et al 2003). Nydén et al 2003 found that safety needs dominated, with patients feeling fairly safe just being in hospital.

A stressful environment

Staff found working in the ED a source of stress. Studies conducted in USA, Canada, UK and Belgium supported this indicating that the problem appeared to be an international one. Several aspects of ED work have been cited as key determinants in staffs' intention to leave their job such as a lack of engagement and high burnout (Sawatzky and Enns 2012) interpersonal conflict (Laposa et al 2003) and lack of control due to the sheer volume of patients (Bergman 2012). Staff reported suffering from a range of symptoms which included sleep disturbances, having an anxious or depressed mood (Stathopoulou et al 2011), intrusive thoughts about patients, avoidance of patients and being easily annoyed (Dominguez-Gomez and Rutledge 2009).

Aggression and violence was a well-documented outcome for staff in the literature and a key source of stress in the ED environment. Studies were reported from a range of

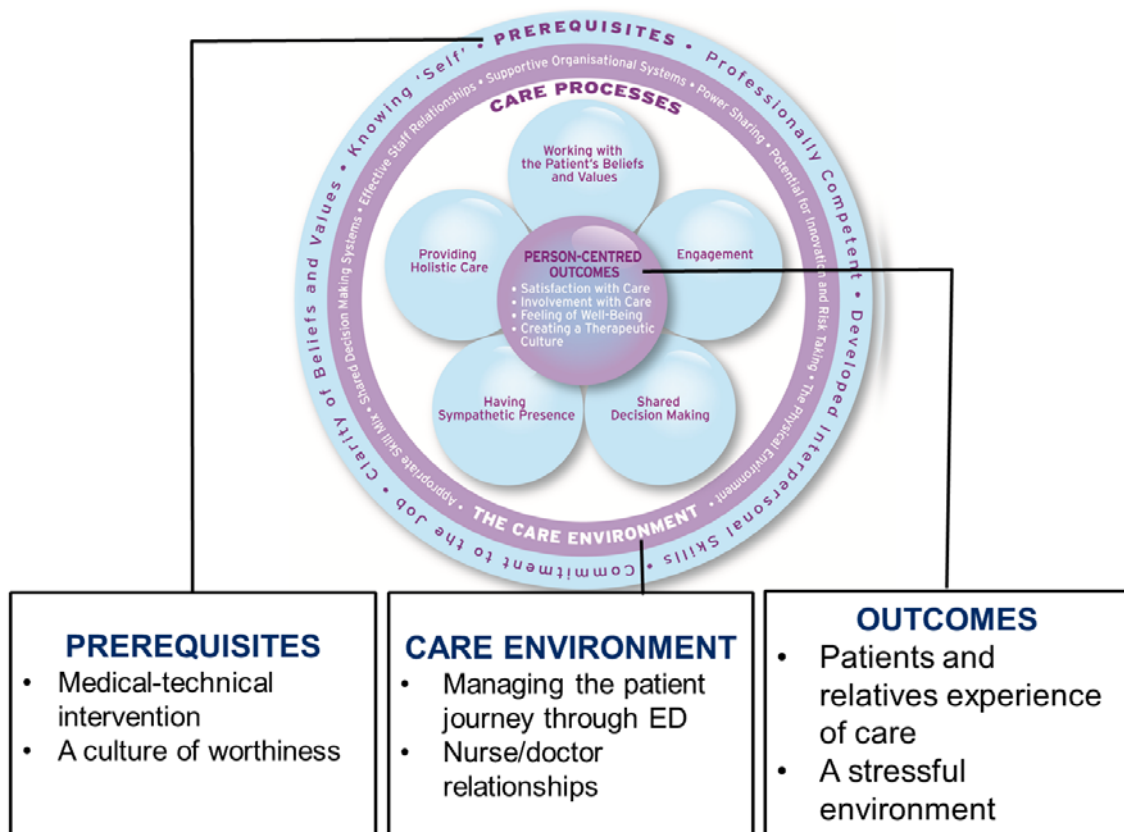
countries including UK, Ireland, Australia, USA and Turkey. Nurses appeared to be the main targets of aggression and violence and negative consequences experienced included feelings of embarrassment, powerlessness, frustration, isolation and vulnerability (Hislop and Melby 2003), anger, anxiety, fear, and decreased job satisfaction. (Kansagra et al 2008) feeling degraded, frustrated and powerless (Pich et al 2011). Two studies highlighted nurses' bewilderment at being targeted by patients and relatives when they were there in a caring capacity. In a UK phenomenological study by Hislop and Melby (2003) one nurse expressed a feeling as if the whole waiting room hated them and stated "*it just wrecks my spirit*" (p 8). Similarly Pich et al (2011, p14) described nurses voicing a lack of empathy towards so-called ungrateful patients who they were trying to help saying it felt like "*being kicked in the teeth*".

Multiple causal factors have been suggested. Patient factors included alcohol and substance misuse (Crilly et al 2004, Gilchrist et al 2011, Pich et al 2011), mental illness (Crilly et al 2004, Gilchrist et al 2011) and a lack of understanding of the system (Gilchrist et al 2011). Environmental factors were also cited such as lengthy waiting times (Gilchrist et al 2011, Kansagra et al 2008, Lau et al 2012), inability to access desired services, (Crilly et al 2004, Gilchrist et al 2011), limited space, overcrowding and lack of information (Angland et al 2014). Several authors identified that in some cases how staff engaged with patients could also be a significant contributory factor. Angland et al (2014) found that at times staff may exacerbate difficult situations by projecting themselves negatively. This was supported by two Australian studies which found that behaviours staff displayed included being overtly authoritative, being judgemental and confrontational (Lau et al 2012) and being rude and condescending to patients (Pich et al 2011).

DISCUSSION

Analysis of the literature would suggest that whilst components of person-centredness have emerged from the empirical evidence, no papers were identified that discussed person-centredness as a concept that relates to care delivery within ED. Although the vocabulary within the studies was not that of person-centredness as defined by McCormack and McCance (2010), the themes presented could be clearly mapped to the aspects within the Person-Centred Practice Framework as illustrated in Figure 2.

Figure 2: Mapping literature themes to the Person-Centred Framework



Prerequisites as described by McCormack and McCance (2010) focus on the attributes of staff and include being professionally competent; having developed interpersonal skills; being committed to the job; being able to demonstrate clarity of beliefs and values; and knowing self. Much of the ED literature related to prerequisites, and in particular that of having clarity of beliefs and values which in turn determined how staff viewed their work, what they valued and how they related to the various patient groups who presented in the department. Themes emerging from the literature that related to these include the focus on 'medical-technical interventions' and the presence of a 'culture of worthiness'. Staff valued medical tasks and interventions over caring and this determined what they felt the nature of ED work should be and what types of patients were considered to be worthy ED presentations. These characteristics are deeply embedded within a culture and may be difficult to recognise and acknowledge, however evidence from the literature would suggest that ED staff need to reappraise their values since according to McCormack and McCance (2010) prerequisites form the foundation for achieving person-centred care.

The care environment as described by McCormack and McCance (2010) focuses on the context in which care is delivered and includes: appropriate skill mix; systems that facilitate shared decision making; effective staff relationships; organisational systems that are supportive; power sharing; and the potential for innovation and risk taking. The themes of 'managing the patient journey through ED' and 'nurse/doctor relationships' related to aspects of supportive organisational systems, effective staff relationships and power sharing within the framework. Within this domain the responsibilities and pressures on ED nurses was apparent in the literature as it revealed how they struggled to manage patients' journeys through a system which was governed by processes outside their control and medical staff over whom they had no authority. Inadequacies within the care environment need to be addressed if person-centred care is ever to be a reality in ED as according to McCormack and McCance (2010) the care

environment has the greatest potential to limit or enhance the delivery of person-centred care.

It was evident from the literature that the ED care environment impacted on how staff engaged in person-centred processes. Person-centred processes as described by McCormack and McCance (2010) focus on delivering care through a range of activities and include working with patient's beliefs and values; engagement; having sympathetic presence; sharing decision making; and providing for physical needs. Various aspects of the framework, in particular from the prerequisites and care environment domains were seen to impact on how care was delivered. For example a concentration on tasks and interventions and the need to maintain patient throughput meant that care delivered was fragmented and staff failed to engage fully with patients. While this was not identified as a major theme within the papers reviewed it was an apparent consequence that was threaded throughout the literature. It is clear from the literature that the demands of ED work impacted on staffs' ability to deliver person-centred processes however McCormack and McCance (2010) contend that a shift in attitudes and behaviours could still enable this to be achieved.

McCormack and McCance (2010) contend that staff must possess certain attributes and work in an appropriate care environment to deliver effective care processes in order to achieve effective person-centred outcomes for patients and staff. Outcomes are the results of effective person-centred practice and include: satisfaction with care; involvement in care; feeling of well-being; and creating a therapeutic environment. A large proportion of the literature focused on negative outcomes for ED staff and patients. Staff experienced a stressful environment due to systems beyond their control, staff relationships and violence and aggression which had negative psychological consequences for them including burnout and a desire to leave ED. Patients' experiences of care in turn was greatly impacted on by how staff interacted with them and the environment in which they were cared for and often resulted in care

that was far from what they would have wished for themselves or their relatives. Various components within the prerequisites, care environment and care processes could be seen to contribute to these outcomes, although this was surmised from the literature as this was not usually the objective of the studies undertaken, indicating that there is value in exploring person-centredness as a concept within an ED context.

CONCLUSION

Person-centred care is comprised of several distinct components which interact with each other and ultimately determine the care experience for staff and patients. The findings from this analysis of the international literature confirm that there are powerful relationships between these various components that are considered crucial to the development of person-centred practice that have not been explored within ED to date. Associations and links originating from the studies have been limited to those found between or within one or two of these components described by McCormack and McCance (2010). Consideration as to how all of the individual components that comprise person-centredness interact with, and impact on each other in the delivery of care within the ED setting has not been explored within the current literature. This information however is vital if the delivery of person-centred care within the ED context is to be realised, and is therefore the focus of the author's current doctoral studies.

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